New Directions in Suicide Safety Planning & Lethal Means Safety: "Project Life Force"- A Manualized Telehealth Group Intervention "+ Other Adaptations"

Marianne Goodman, MD

Professor, Icahn School of Medicine at Mount Sinai

Associate Director, VISN 2 Mental Illness Research, Educationand Clinical Center (MIRECC)

Director, Suicide Prevention Research & Treatment Progran James J. Peters VAMC, Bronx NY

New York / New Jersey MIRECC

RESEARCH AND PREVENTION IN SERIOUS MENTAL ILLNESS

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Stop Soldier Suicide
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Conflicts of Interest

- None to report

Disclaimer: The views or opinions expressed in this talk do not represent those of the Department of Veterans Affairs or the United States Government.

Suicide Specific Evidence Based Treatment (EBTs)

10,000 foot view

Evidence Based Treatments

- Dialectical Behavior Therapy (DBT)*
- CBT-SP
- Collaborative Assessment and Management of Suicidality (CAMS)

Brief EBTs

- Safety Planning**
- Counseling About Lethal Means (CALM)*

*Focus of today's seminar.

Suicide Specific EBTs

Evidence Based Treatments

- DBT
- CBT-SP
- Collaborative Assessment and Management of Suicidology (CAMS)

Brief EBTs

- Safety Planning
- Counseling About Lethal Means (CALM)

Today's cyberseminar is going to focus on DBT + Suicide Safety Planning (SSP) & LMS

Suicide Safety Planning

Best Practice

- **Safety Planning PRISMA-Review (Ferguson et al, 2021)**
- Search terms: **safety planning**, **suicide**
- n=565 articles screened

→ 26 articles eligible

- 50% stand-alone safety planning,
- 50% safety planning + other interventions
- n=20 “in person” format
- n=14 had suicide-specific outcomes
- n=3 included groups

Outcomes

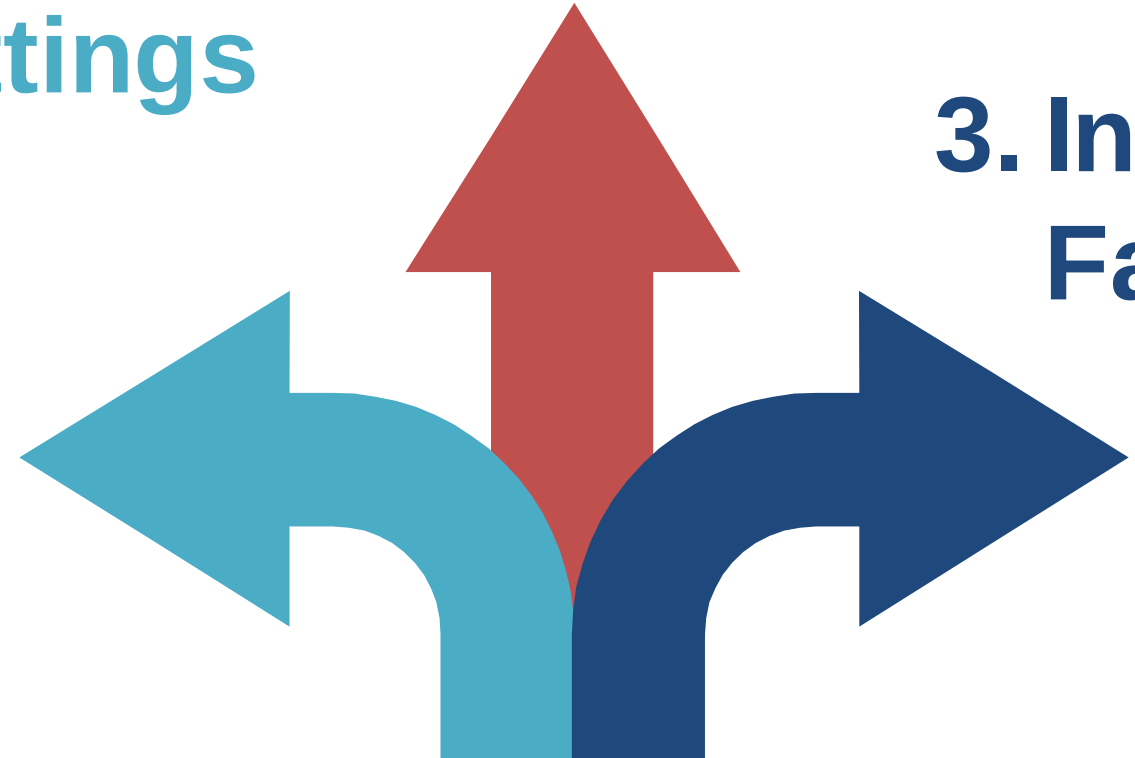
- Improvements in suicidal ideation & behavior, depression, hopelessness,
- Good acceptability and feasibility

Suicide Safety Planning: New Directions

1. Group Settings

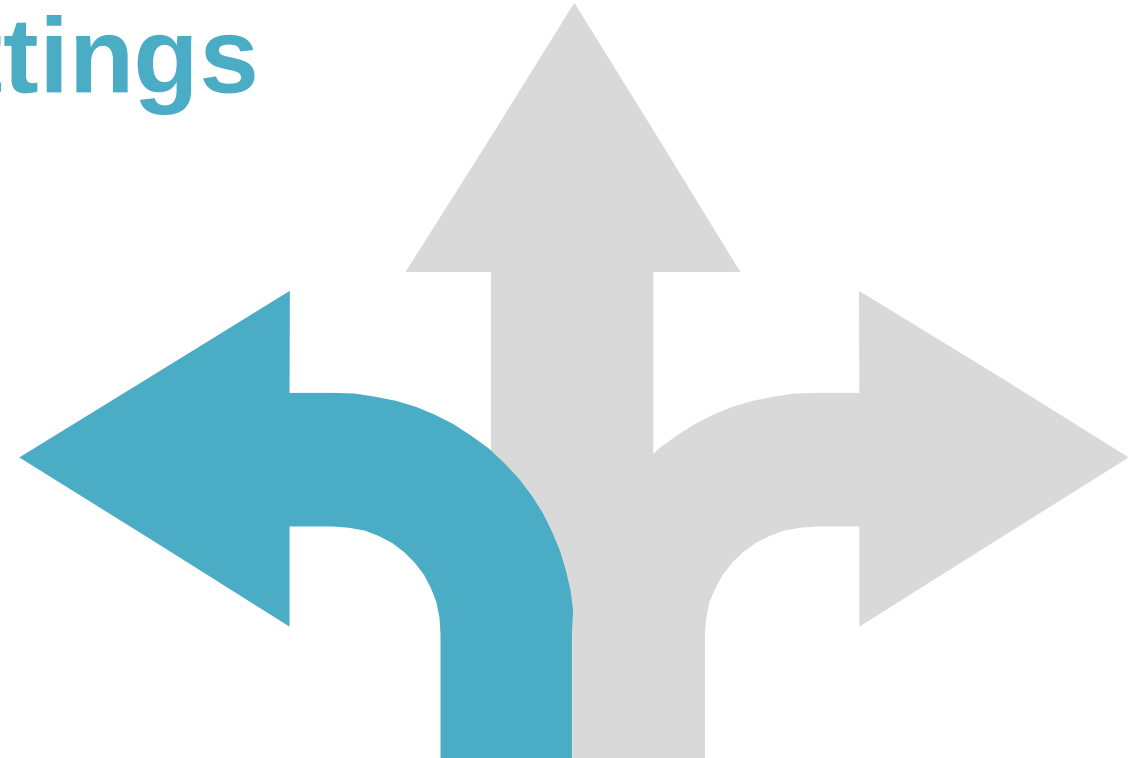
2. Telehealth Delivery

3. Involving Family



Suicide Safety Planning: New Directions

1. Group Settings



Suicide Safety Planning: Groups

PRISMA-Scoping Review Questions

1. What research exists on **group** interventions with **suicide-specific outcomes?**

2. What about the **efficacy** of these interventions?

3. Which of these interventions utilize **safety planning?**

Prisma Review: Suicide & Groups

1. Restricted to “group only” modality, suicide openly discussed, research trial
2. 1369 articles screened → 10 included
    1. n=8 included skills training, n=4 included reasons for living
    2. n=5 included aspects of safety planning
    3. Weekly, 8-20 sessions
    4. Minimal rigor, most were open label (n=7)
    5. All 10 highlighted improvements in suicide related outcomes

(Sullivan et. al, in press)

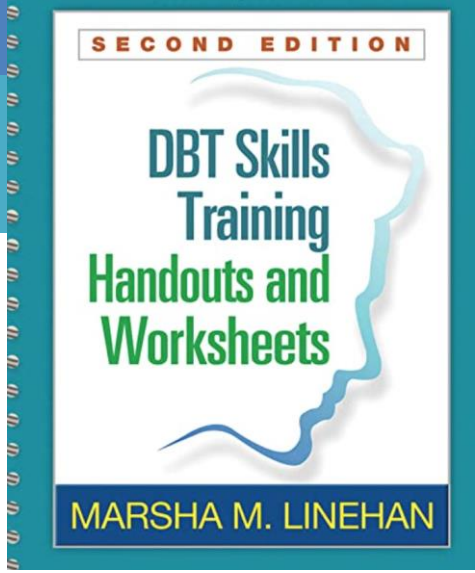
Project Life Force (PLF)

Main Objective

- Keeping high-risk Veterans alive through a **group safety planning intervention**

In collaboration with

- Greg Brown, PhD
- Barbara Stanley, PhD
- Michael Thase, MD



Life Before PLF

Early adopter of DBT in the VA

*ran Bronx VA DBT program (2003-2017)

*directed VISN 2 MIRECC education project trained 7 VA teams in DBT (2007; Marsha Linehan was the trainer)

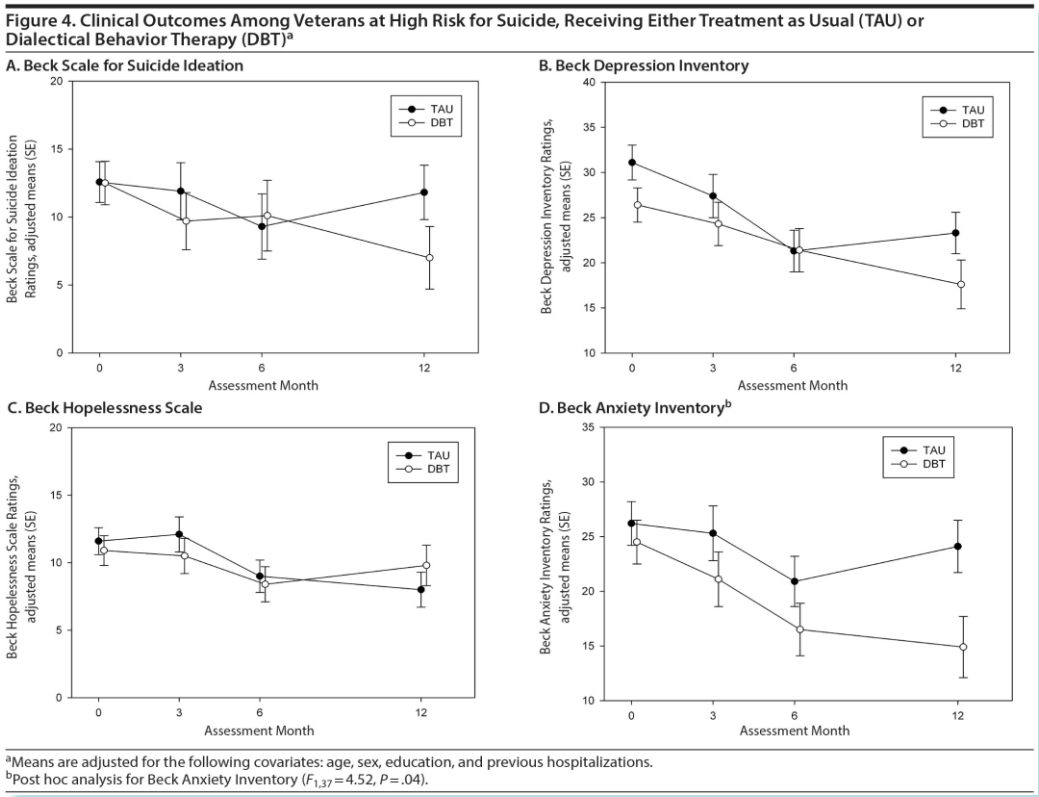
*CSRD CDA (2007-2010), neurobiological underpinnings of DBT treatment response

*DoD RCT of DBT (2010-2015)

….. I was all 'in' (until 2015)

…In 2018, I did receive the "DBT Research Award" at ISITDBT

Project Life Force: Origins



Methods

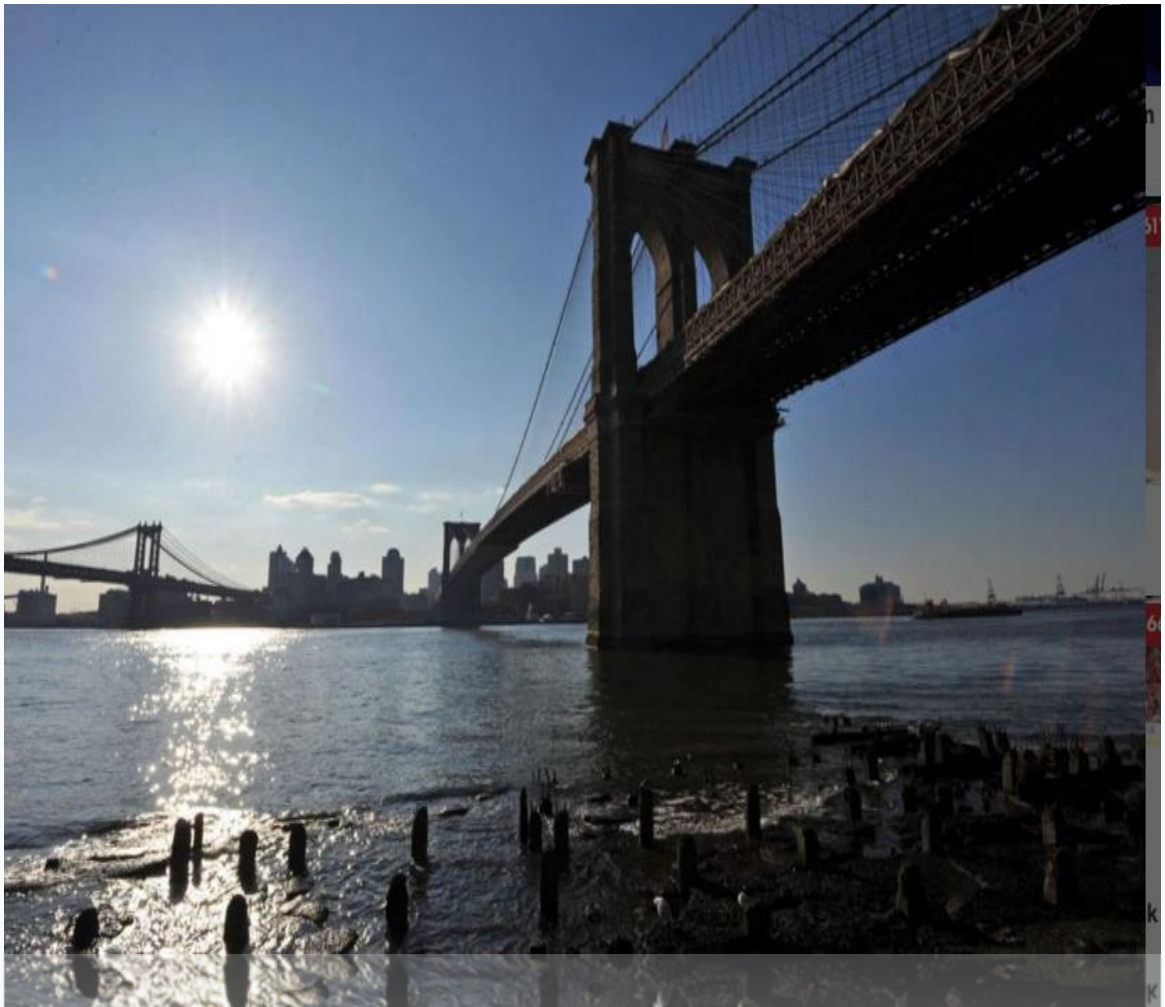
- 6-months of **DBT vs. TAU**
- 93 high-risk suicidal Veterans

Results

- ***Negative study***
- Both groups **improved in *all*** outcome measures

Dialectical Behavior Therapy (DBT) Trial in Suicidal Veterans (Goodman et. al, 2016)

Personal Anecdote



Suicide Safety Plan: Usage Study

Qualitative Study (Kayman et al., 2015)

- 20 Veterans interviewed after creating their SSP
- Follow-up interview 1 month later

Notable Findings

- Wide range of use (none–several times daily)
- Importance of clinician collaboration
- Both **obstacles and facilitators** of SSP use

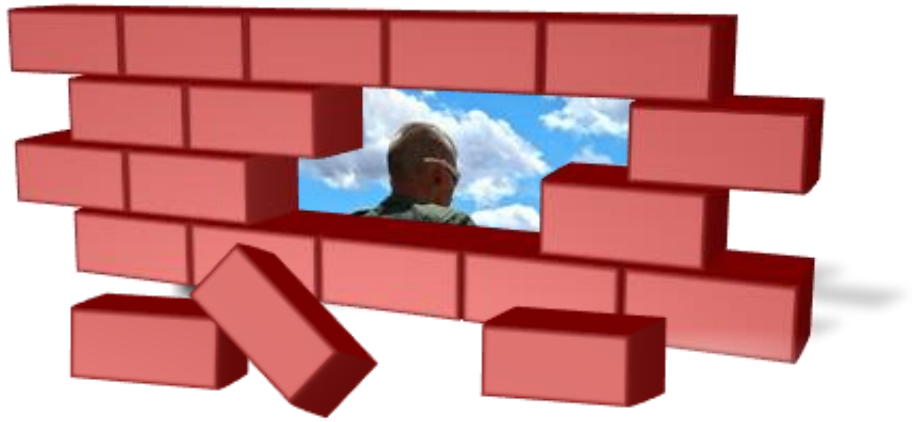
Suicide Safety Plan: Usage Study

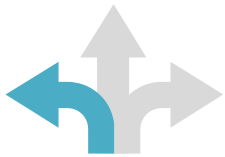
Obstacles

- Lack of social network
- Social withdrawal/ depression
- Avoidant coping style
- Burden too great to carry out plan alone

Facilitators

- Sharing of plan with significant others
- Mobile format of SSP
- Individualized plans

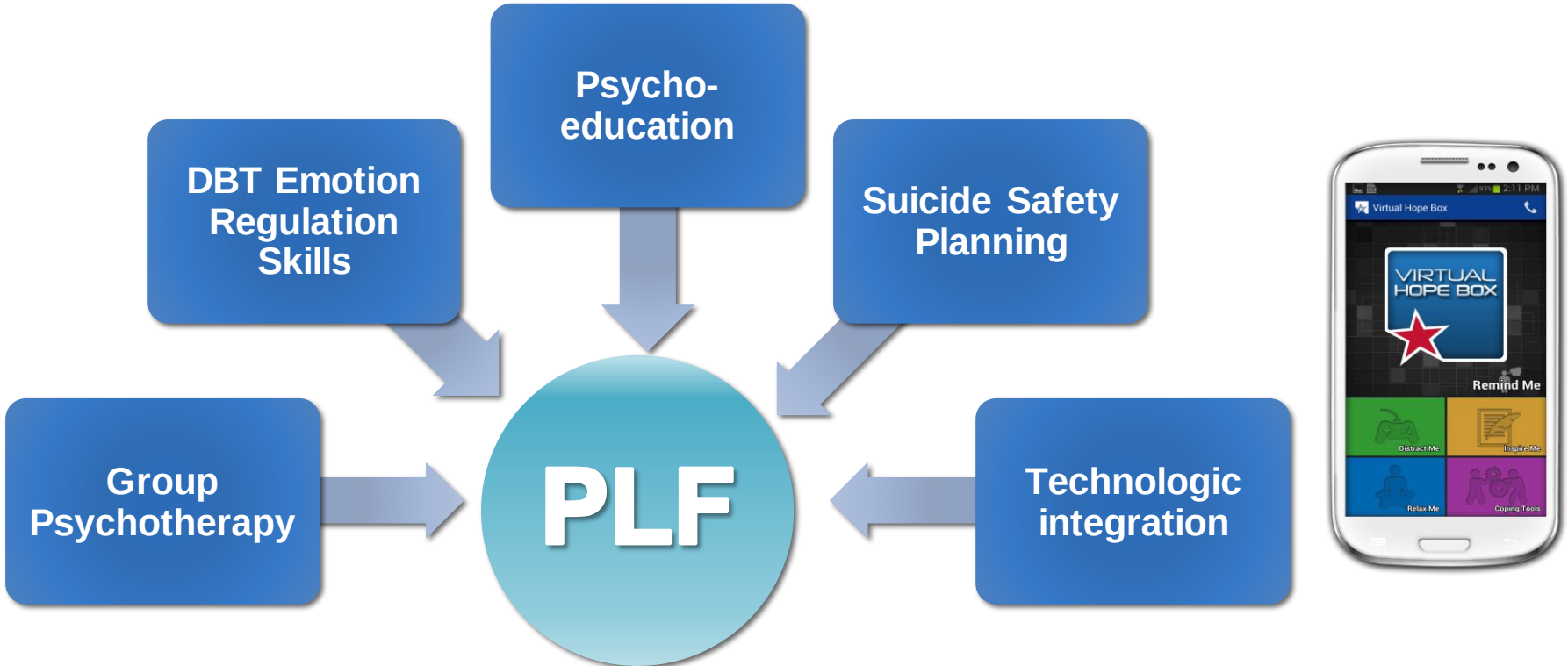




- Teaching distress tolerance and emotion regulation **skills at each step** of their SSP
- Introduces use of a **mobile SSP app**
- Helps Veterans identify those they can call for help, and **practice asking for help**
- Aims to develop **detailed, personalized, and meaningful** SSPs
- Delivered in a **group context** for offering peer support

Project Life Force: Overview

- **Manualized** group therapy
- 10 x 90-minute sessions
- **From development to implementation** of SSP



Project Life Force: SSP

Session 1

- Identifying crisis prevention services

VA Suicide Prevention Resource Coordinator Name_____

VA Suicide Prevention Resource Coordinator Phone_____

VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician

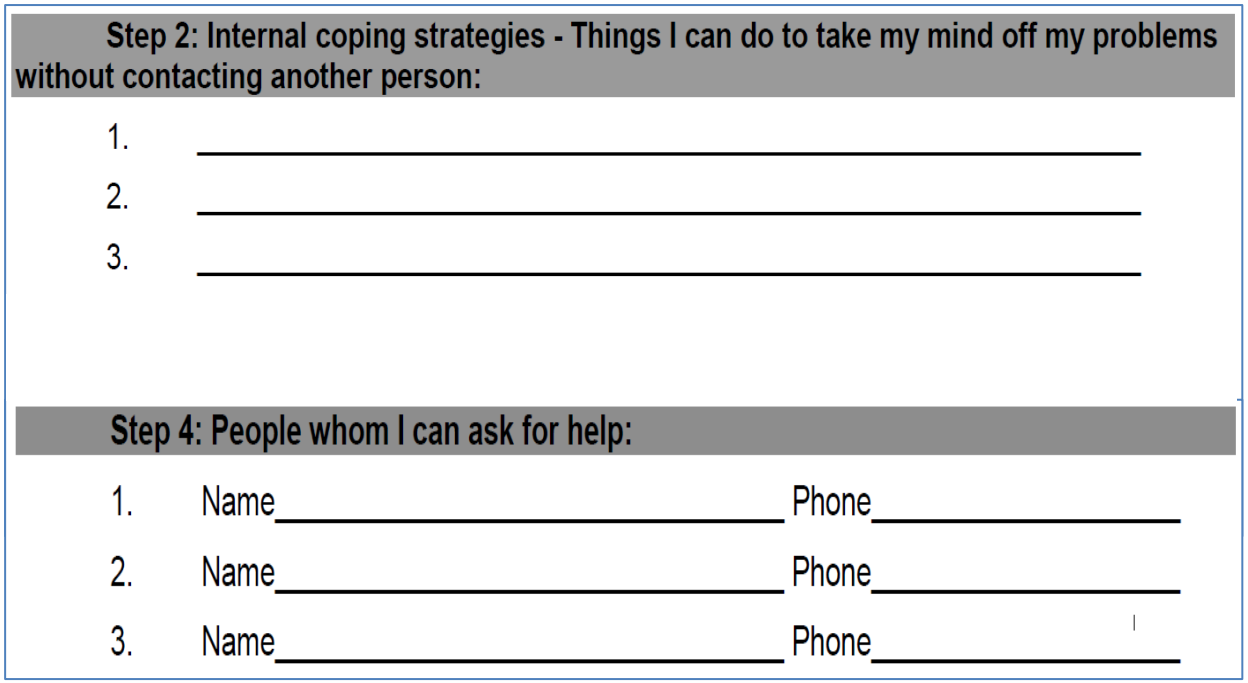
Session 2

- Emotion recognition skills

Step 1: Warning signs:

1. _____
2. _____
3. _____

Project Life Force: SSP



Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Session 3

- Distress tolerance

Sessions 4-5

- Interpersonal communication skills with **family members**

Project Life Force: SSP

Session 6

- Interpersonal communication skills w/ clinical team

Session 7

- Means restriction

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008).

Project Life Force: Sessions

- PLF is **one of the only** manualized outpatient **group treatments** for suicidal individuals

	Project Life Force Session Outline	
Session	**Session Focus**	**Skill Covered**
1	**Introduction, psychoeducation about suicide, SSP step #5 - crisis numbers, meet local SPC**	**Crisis Management skills Urge Restriction**
2	**SSP step #1 - Identification of Warning Signs**	**Emotion, Thought or Behavior Recognition skills**
3	**SSP step #2 - Internal Coping Strategies**	**Distraction skills**
4	**SSP step #3 - Identifying people to help distract**	**Making Friends Skills**
5	**SSP step #4 - Sharing SSP with Family**	**Interpersonal Skills**
6	**SSP step #5 - Professional Contacts**	**Skills to maximize Treatment efficacy & Adherence**
6	**SSP step #6 - Making the Environment Safe**	**Means restriction, psychoeducation about methods**
7	**Improving Access to the SSP**	**Use of Safety Planning Mobile Apps and Virtual Hope Box**
8	**Physical Health Management**	**Decreasing Vulnerability to negative Emotion**
9	**Building a Positive Life**	**Building Positive Emotion**
10	**Recap/Review**	

Project Life Force: Pilot Outcomes

Routledge
Taylor & Francis Group

search

After 10 weeks of PLF, Veterans had:

>40% ↓ suicide symptom severity/ideation,

>30% ↓ depression,

>20% ↓ hopelessness

Journal homepage: https://www.tandfonline.com/loi/usui20

ide Safety Planning Group

fe Force"

livan, Angela Page Spears, Lisa Dixon, Yosef
langa C. Galfalvy, Erin A. Hazlett & Barbara

Feasibility/Acceptability Pilot Data

- *N*=45
- **<2.0 total hours/week per clinician**
- Veteran satisfaction 4.7 out of 5 point Likert scale
- 5.0 of 5 rating on recommending the treatment to others
- **<17% attrition**
- 100% of participants updated their SSPs and increased use patterns.

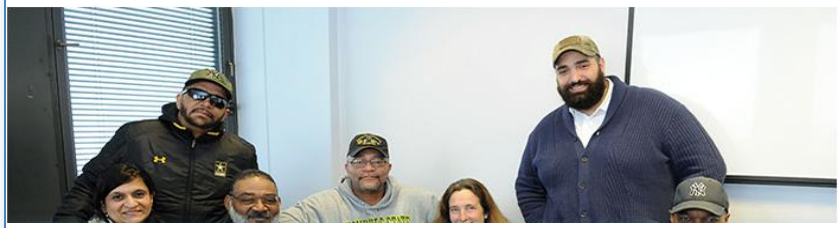
Project Life Force: In The News

Online group therapy keeps Veterans connected

VA CONNECT program helps Vets cope

Wednesday, April 7, 2021 10:00 am | Coronavirus, Health | VAntage Point Contributor | 801 views

VA RESEARCH CURRENTS
Research News from the U.S. Department of Veterans Affairs



Vet arranges flag honor for doc's life-saving work

Bronx VA psychiatrist-researcher cited for work in suicide prevention

Tuesday, September 24, 2019 10:00 am | Health, Inside Veterans Health | Mitch Mirkin | 3k views

Project Life Force helps Veterans cope with suicidal urges

"You often hear negative news about the VA, specifically related to suicide. We don't recognize the hard work and achievements of our providers, which is why I wanted to honor Dr. Goodman. Sometimes we need to recognize good work in the news."

Project Life Force: RCT Protocol

ELSEVIER

Contemporary Clinical Trials Communications

Volume 17, March 2020, 100520

Research paper

Group ("Project Life Force") versus individual suicide safety planning: A randomized clinical trial

Marianne Goodman [a, b], Gregory K. Brown [c, d], Hanga C. Galfalvy [e], Angela Page Spears [a], Sarah R. Sullivan [a], Kalpana Nidhi Kapil-Pair [a, b], Shari Jager-Hyman [c], Lisa Dixon [e, f], Michael E. Thase [c, d], Barbara Stanley [f]

Project Life Force: RCT Protocol

Progress to Date*

Site	Total Enrolled
JJP VAMC (Bronx)	140
CMC VAMC (Philadelphia)	72
Total	**212**

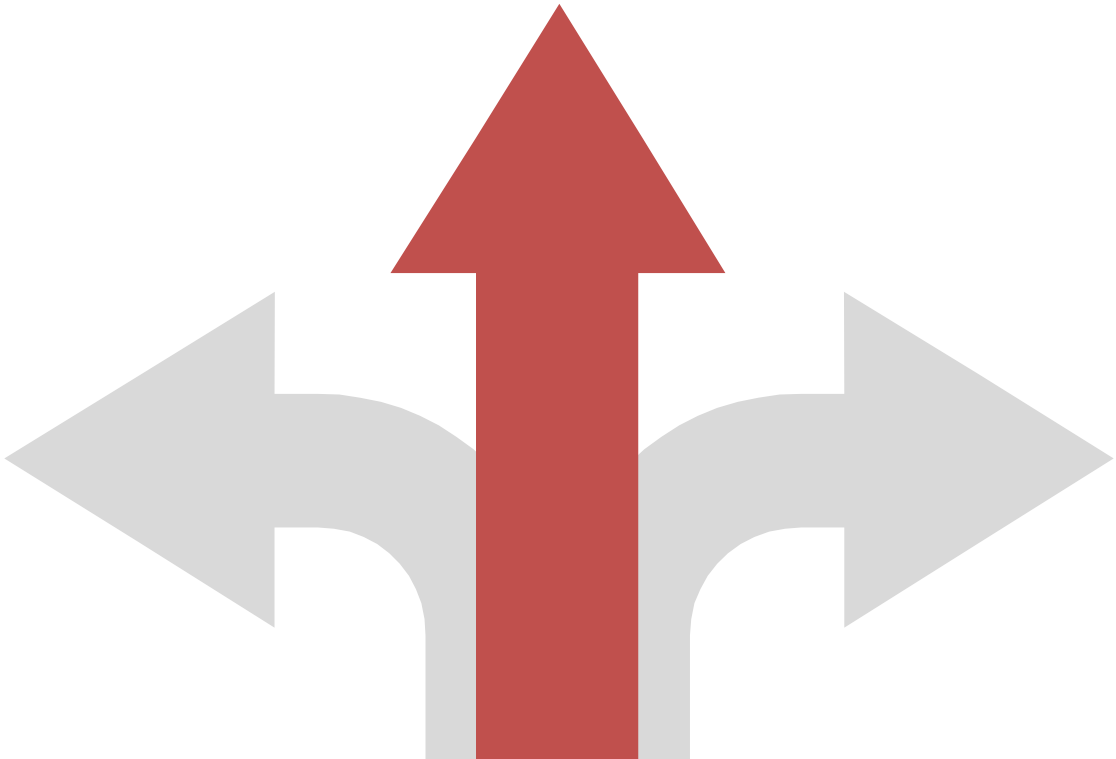
161 group sessions between both sites

- Of these, **>80 were virtual groups**

*Since October 8, 2021

Suicide Safety Planning: New Directions

2. Telehealth Delivery



Telehealth & Suicide Specific Care

Importance & Rationale

- Barriers to accessing in-person care existed even prior to the COVID-19 pandemic
  - (Lee et al., 2015; Jacobs et al., 2019)
- Barriers included (Chen et al., 2020):
  - inflexible work schedules,
  - travel costs,
  - health issues,
  - caregiving responsibilities and,
  - physical disabilities
- These barriers are especially prevalent for individuals residing in rural areas, who may experience elevated risk of suicide but have the least access to care
  - (Andrilla et al., 2018; Hirsch & Cukrowicz, 2014)

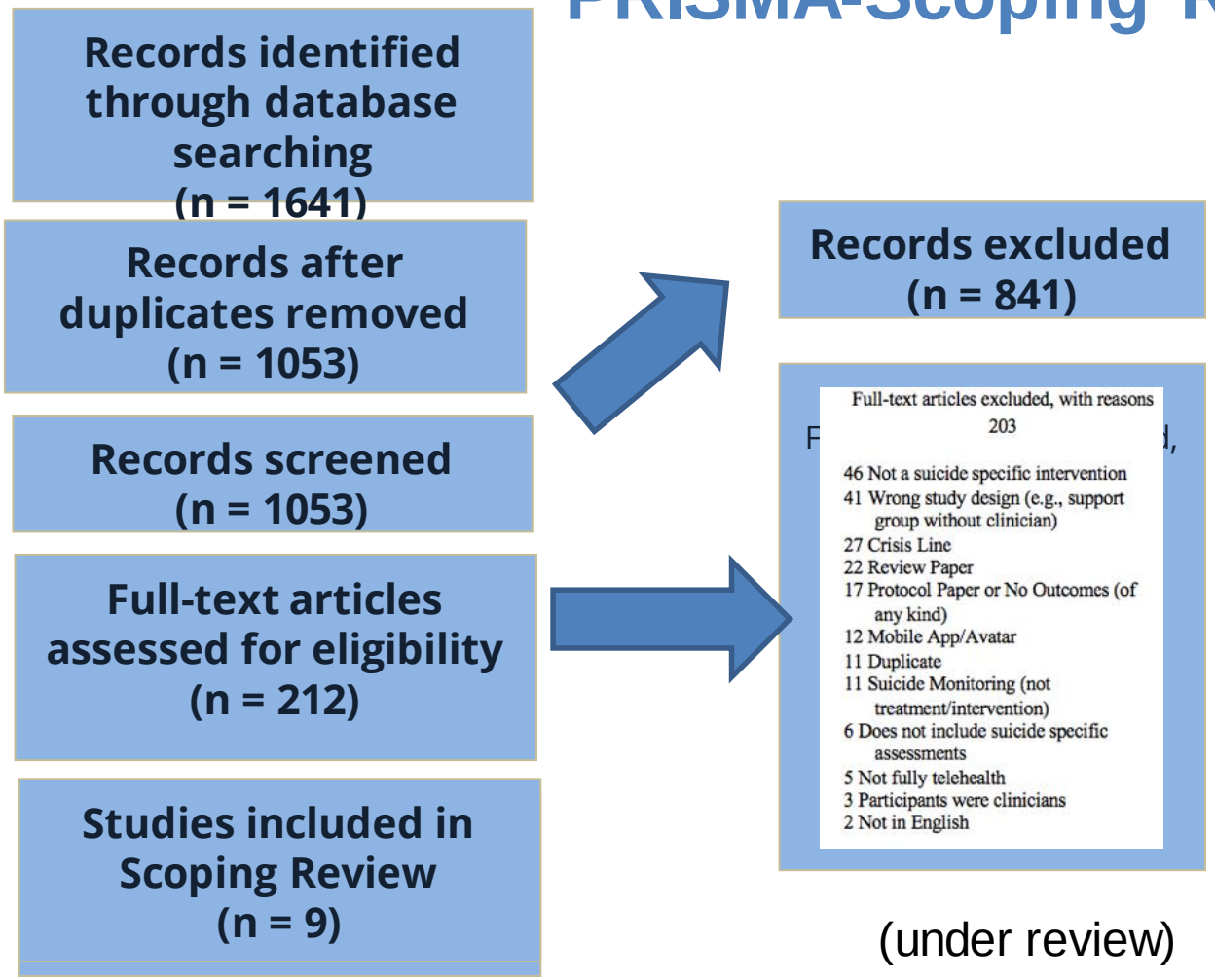
Telehealth & Suicide Specific Care

PRISMA-Scoping Review Questions

- What research exists on current **"full" telehealth** clinical interventions with **suicide specific outcomes?**
- What is known regarding the **efficacy** of these interventions?
- Which of these interventions utilize **Safety Planning?**

Telehealth & Suicide Specific Care

PRISMA-Scoping Review



(under review)

Telehealth & Suicide Specific Care

PRISMA-Scoping Review: Results 1

- EBTs delivered via telehealth do **NOT** have empirical support yet
- Seven (77.8%) of the nine studies noted a follow-up intervention targeting patients discharged from the ED,
  - Telehealth session length ranged from 5-40 minutes; the average across studies was 22.6 minutes.

** Timing of review did not capture telehealth conversion prompted by pandemic

Telehealth & Suicide Specific Care

PRISMA-Scoping Review: Results 2

- Two studies reported incorporating Lethal Means Counseling
  - (Gabilondo et al., 2019; Rengasamy et al., 2019)
- Only one of these studies also provided safety planning
  - (Rengasamy et al., 2019)

** Timing of review did not capture telehealth conversion prompted by pandemic

Project Life Force: Telehealth (PLF-T)

In collaboration with

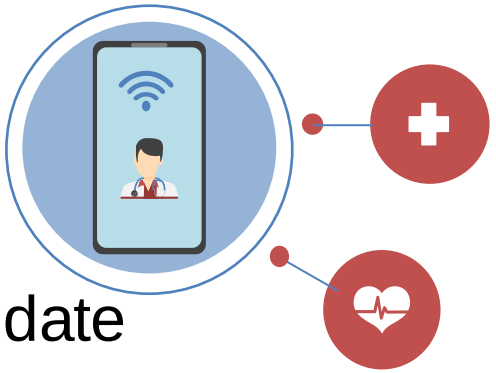
- Shari Jager-Hyman, PhD
- Sapana Patel, PhD
- Rebecca Raciborski, PhD
- Sarah Landes, PhD

Adaptations

- Communication coordinator
- Tried multiple platforms
  - WebEx allows for both phone and video
- Use share screen for manual & updating SPIs

Progress

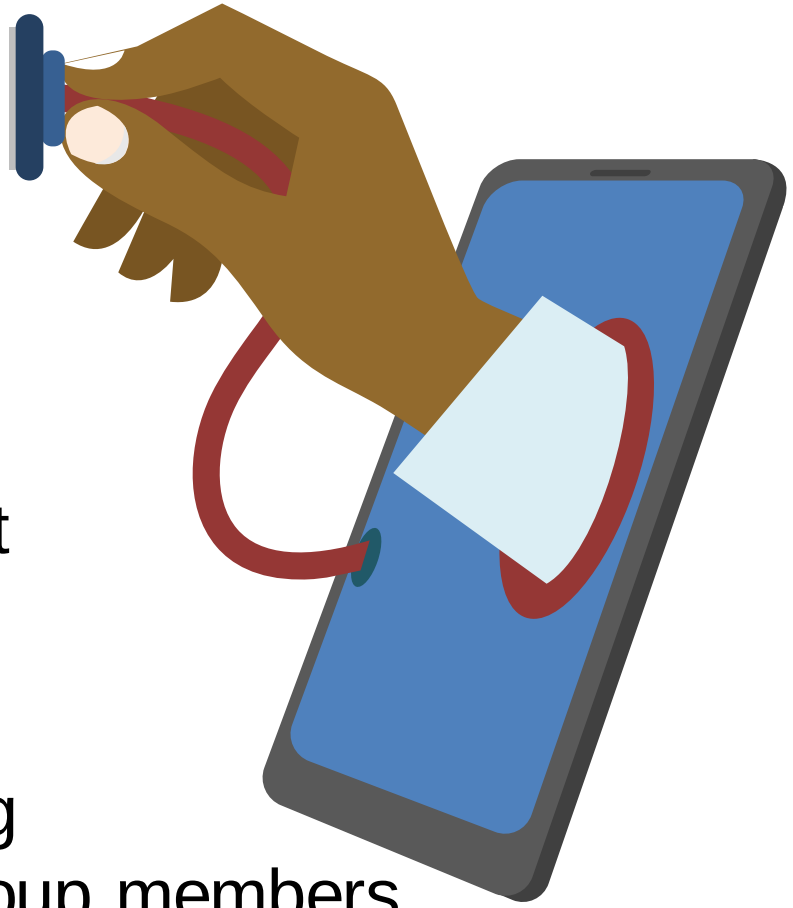
- Teleworking began 3/17/2020
- First telehealth group was 3/18/2020
- >80 PLF sessions offered over telehealth to date



Project Life Force: Telehealth

Lessons Learned

- Creative in addressing barriers:
  - Issues with connectivity
  - Noise
  - Privacy
- Assessment and management of high-risk behavior
- Maintaining group cohesion
- Lack of smart phones, working with VA to attain tablets for group members



Project Life Force: Telehealth

Benefits

- Combine groups across sites
- Include patients across state lines
  - Reduces the barrier of travel
- Allows for expansion beyond initial recruitment sites

Acceptability, Appropriateness, and Feasibility of PLF over Telehealth: AIM/FIM/IAM Assessment

	M
Acceptability	**17.22**
Meets Approval	4.56
Appealing	4.11
Like Intervention	4.33
Welcome Intervention	4.22
Appropriateness	**17.78**
Fitting	4.22
Suitable	4.56
Applicable	4.44
Good Match	4.56
Feasibility	**18.22**
Implementable	4.44
Possible	4.67
Doable	4.67
Easy to Use	4.44

Note: *n*=15. Acceptability, Appropriateness, and Feasibility sum scores based on each 4-item scales. Each item is scored on scale of 1-5, with 5 indicating strong agreement. Each subscale score is calculated by summing the 4 corresponding items for a total range of 5 to 20.

Qualitative Interview for PLF group telehealth participants

- Tell me about your experience participating in PLF via telehealth.
  - What was it like for you to do PLF over VVC?
    - *Only if needed:*
    - What did you like best about doing it in this format?
    - What did you like least?
- Were there any obstacles you had to overcome in order to participate in PLF telehealth?
    - Would these same obstacles also get in the way of participating in in-person groups?
    - Are there any other obstacles that could get in the way of participation in in-person groups? Do these also apply to PLF telehealth?
  - Is there anything about PLF telehealth that made it easier for you to participate? What about things that made it easier for you to participate in groups that meet in person?
- Have you received any other care during COVID-19?
  - How did that care compare to PLF over VVC?
- In what ways did the PLF intervention impact your suicidal thoughts or actions during COVID-19?
  - Did it in any way affect feelings of isolation?
  - Did it help you get rid of any lethal means (or things you could use to harm yourself) in your living space?
  - What was it like to be in a group with people you have never met?
    - *Probe:* Both facilitator and group members AND particularly in other states
- How did participating via telehealth affect your openness to talking about suicide with the group?
  - How did participating via telehealth affect your openness to talking about suicide with other people in your life?
- Have you noticed any change in your usage of the safety plan?
  - *Probe:* If yes: Can you describe these changes? If no: Can you describe your baseline safety plan usage since there were no changes?
- In your opinion, would doing PLF over the phone or online (e.g., WebEx) for the entire treatment be of interest to you? Why or why not?
  - Would you recommend it to a friend/fellow Veteran?
  - If given the preference, what would you prefer – WebEx or in person?
  - Would this still be the case if not for COVID?
- Do you have any suggestions for how we could improve PLF telehealth?

Also currently funded with CSRD Supplement for economic analysis- in progress

Project Life Force: Telehealth Qualitative Themes

Positives:

- maintained ability to disclose suicidality/mental health problems,
- surprising comfort with telehealth delivery
- heightened access with telehealth,
- confidentiality maintained appropriately
- benefits of social support, mitigating isolation
- improvements suicidal symptoms
- positive perception of group experience via telehealth,

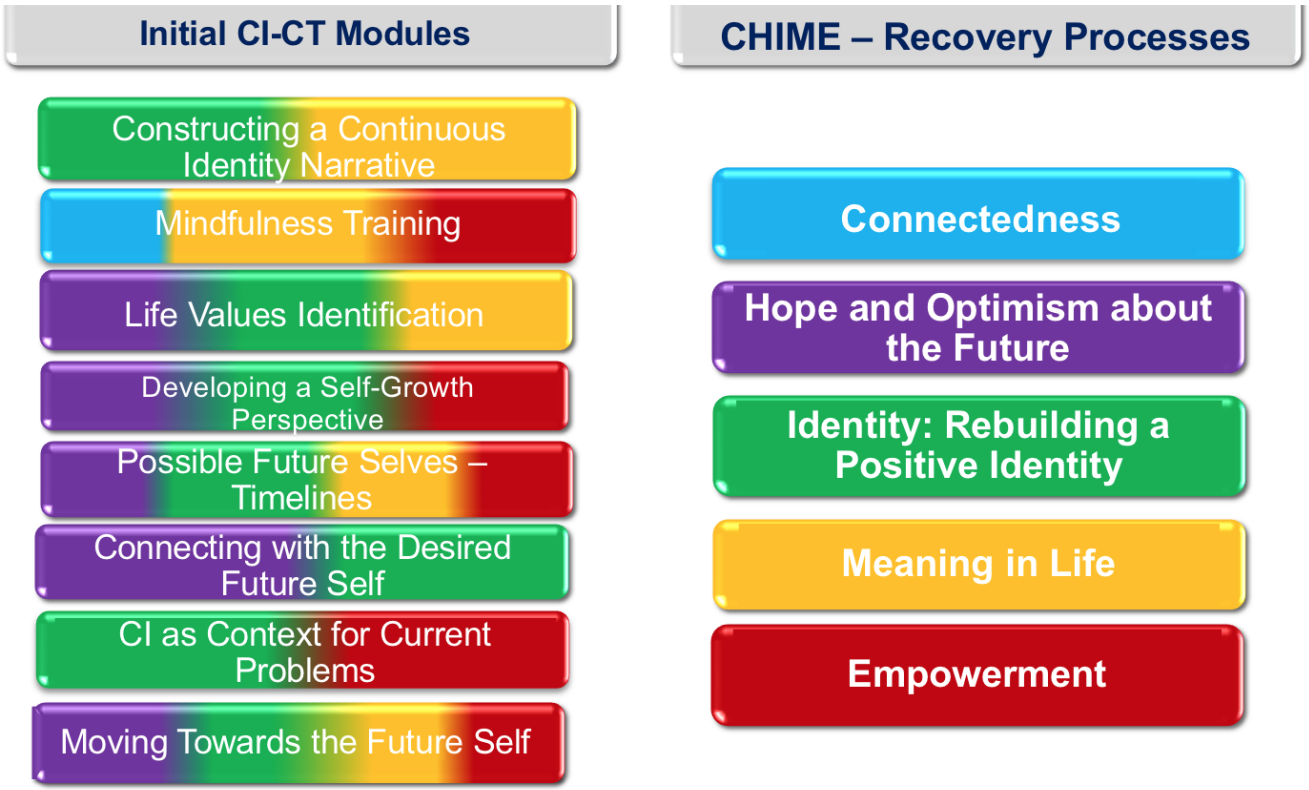
Negatives:

- some difficulties with technology

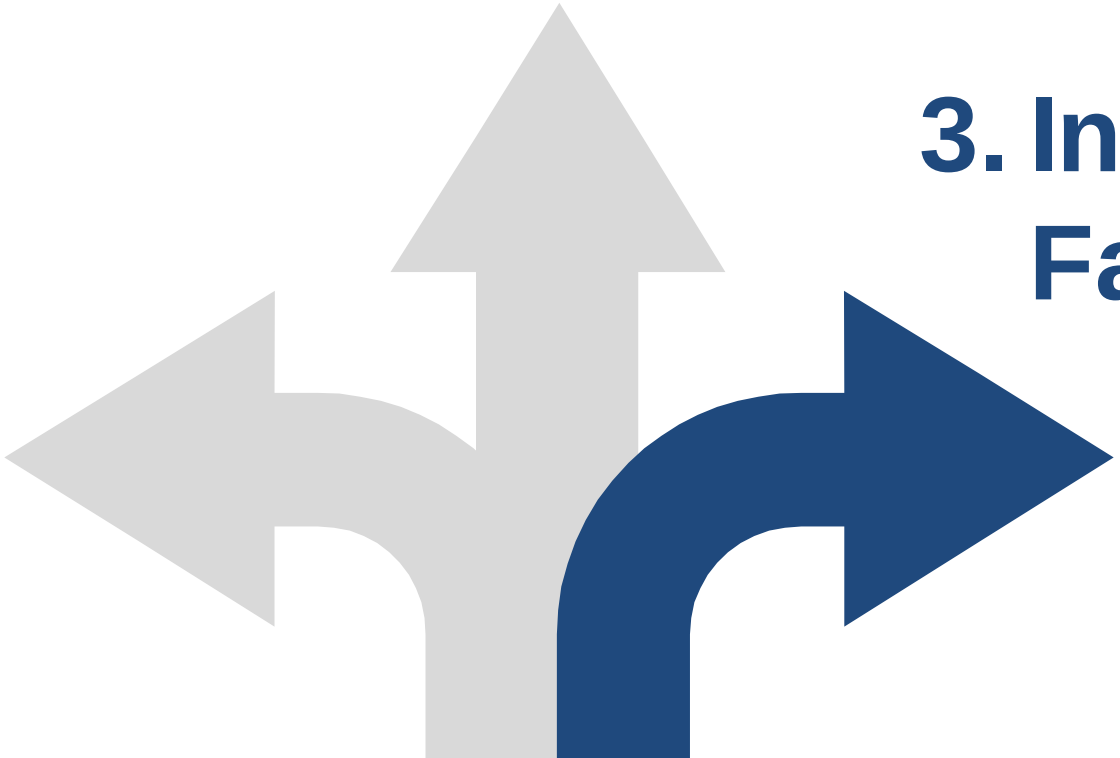
Newest Project: PLF-Rural Veterans (RV)

- Just funded Oct 2021 SPRINT
- Piloting PLF-T in rural populations and Veterans *who do not seek VA care* in Baxter County, Arkansas
- type 1 hybrid effectiveness-implementation design
- **In collaboration with:**
  Angie Walisky PhD
  Sapana Patel, PhD
  Bradford Felker, MD

POST-PLF: currently being developed, recovery based post-acute suicide treatment focusing on "continuous identity"- Dr. Yosef Sokol (CDA-2)



Suicide Safety Planning: New Directions



3. Involving Family

Involving Family in Suicide Specific Care

Rationale:

- The impact of family systems on suicide prevention remains largely unstudied (Frey, Hans, & Sanford, 2016)
- In addition to family as a suicide risk factor, it has also been found to be protective through cohesion, connection, and positive emotional support (Chioqueta & Stiles, 2007; Wagner, Silverman, & Martin, 2003).
- Spirito's (1997) review of clinical interventions, which integrate suicide prevention and family systems, concluded that the **family is a promising target for intervention.**

Safe Actions For Families To Encourage Recovery (SAFER)

PILOT RCT RESULTS

In collaboration with:

Dev Crasta, PhD

Shirley Glynn, PhD

Deborah Perlick, PhD

Barbara Stanley, PhD

RR&D MERIT (PI: GOODMAN)

Rationale for Family Involvement- Pilot Study

- Our research team conducted a qualitative interviews (*n* = 26 Veterans, 19 family members) to elicit perspectives on involving families/loved ones in Veteran's suicide prevention efforts.
- <u>Veteran themes</u>

1) **Isolation**: "I have a big family but it's like I have none"
2) **Shame**: "Deep down a part of it is shame"
3) **Perceived burden**: "I felt like a burden, I wanted to reach out but didn't"
4) **Mistrust**: "They'll flip out or won't understand"

Rationale for Family Involvement- Pilot Study cont.

- Family themes

1) **Perceived inability** to stop their loved one from hurting themselves: “it’s hard for me to find out things that’s going on with him; he keeps it to himself a lot”
2) **Fear of triggering urges**, “I never know how he’ll react”
3) **Feeling unsupported**, “There’s no real support” and
4) **Feeling overwhelmed**, ”I didn’t know what to do”

- Overall, while Veterans felt alone and afraid to reach out to family members, family members also did not know how to support or react to their Veterans suicidality.
- *This data served as the basis for the SAFER intervention.*

SAFER Protocol

1. **Aim:** encourage discussion regarding suicidal symptoms and coping via the development of both a Veteran and a complementary family member safety plan
2. **Approach:** psychoeducation, facilitate disclosure, review of communication skills

   SAFER is a novel, *manualized*, weekly, 90-minute, individual + 4-session family-based treatment

   - Builds complementary Veteran and **"supportive partner" safety plan**

S.A.F.E.R. Suicide Safety Plan for Veteran and Family Member

Veteran	Family Member
STEP 1: Recognizing Warning Signs	**STEP 1: Recognizing Warning Signs/Raising with Veteran**
STEP 2: Using Internal Coping Strategies	**STEP 2: Coaching Veteran on Use of Coping Strategies**
STEP 3: Social Contacts Who May Distract from the Crisis	**STEP 3: Facilitating Veteran's Use of Supportive Social Contacts**
STEP 4: Family or Friends Who May Offer Help	**STEP 4: Providing Direct Support (e.g., Active Listening)**
STEP 5: Professionals and Agencies to Contact for Help	**STEP 5: Facilitating Contact with Professionals/Agencies**
STEP 6: Making the Environment Safe	**STEP 6: Making the Environment Safe**

39 Veteran⇔Support Dyads

Veteran (n=39)

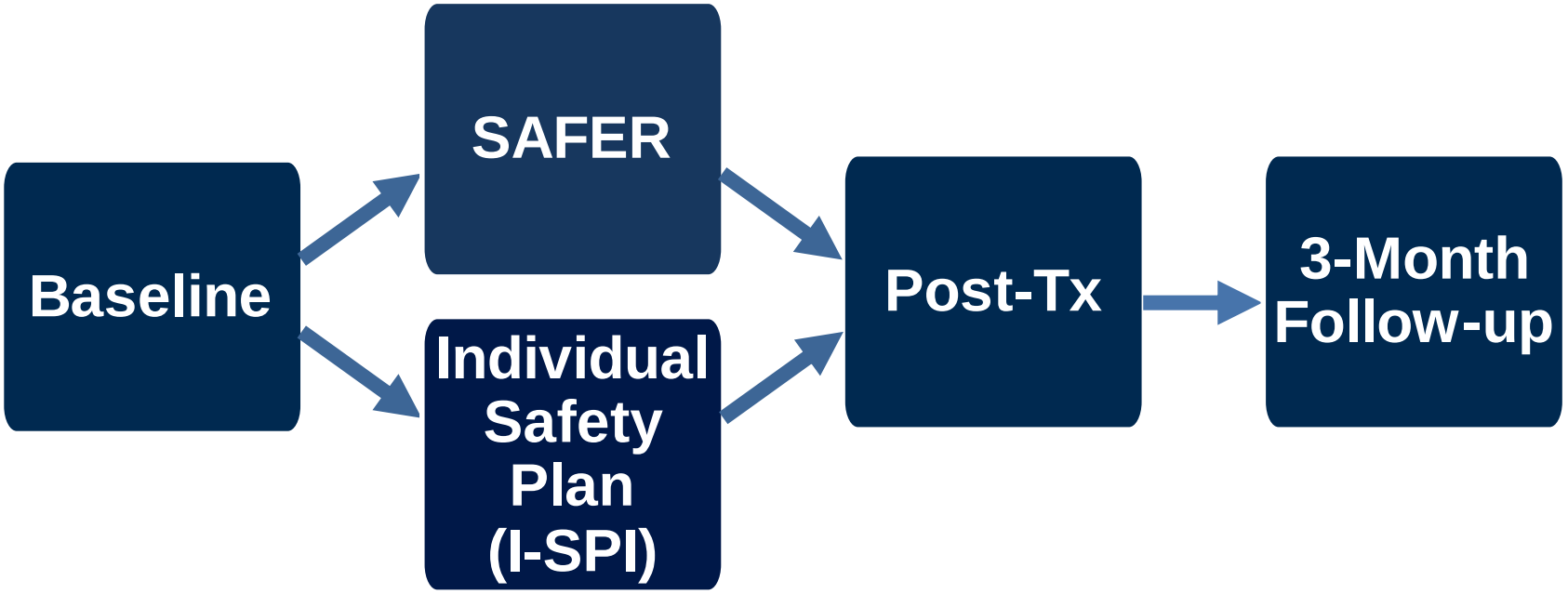
20 with last-month SI
2 with lifetime attempt
17 with BOTH SI/attempt

Support Partner (n=39)

14 romantic partners/spouses
13 other family members
12 close friends

KEY DEMOGRAPHICS	%
Age	**49 years**
Male	**62%**
Hispanic/Latino	**35%**
Black/African-American	**49%**

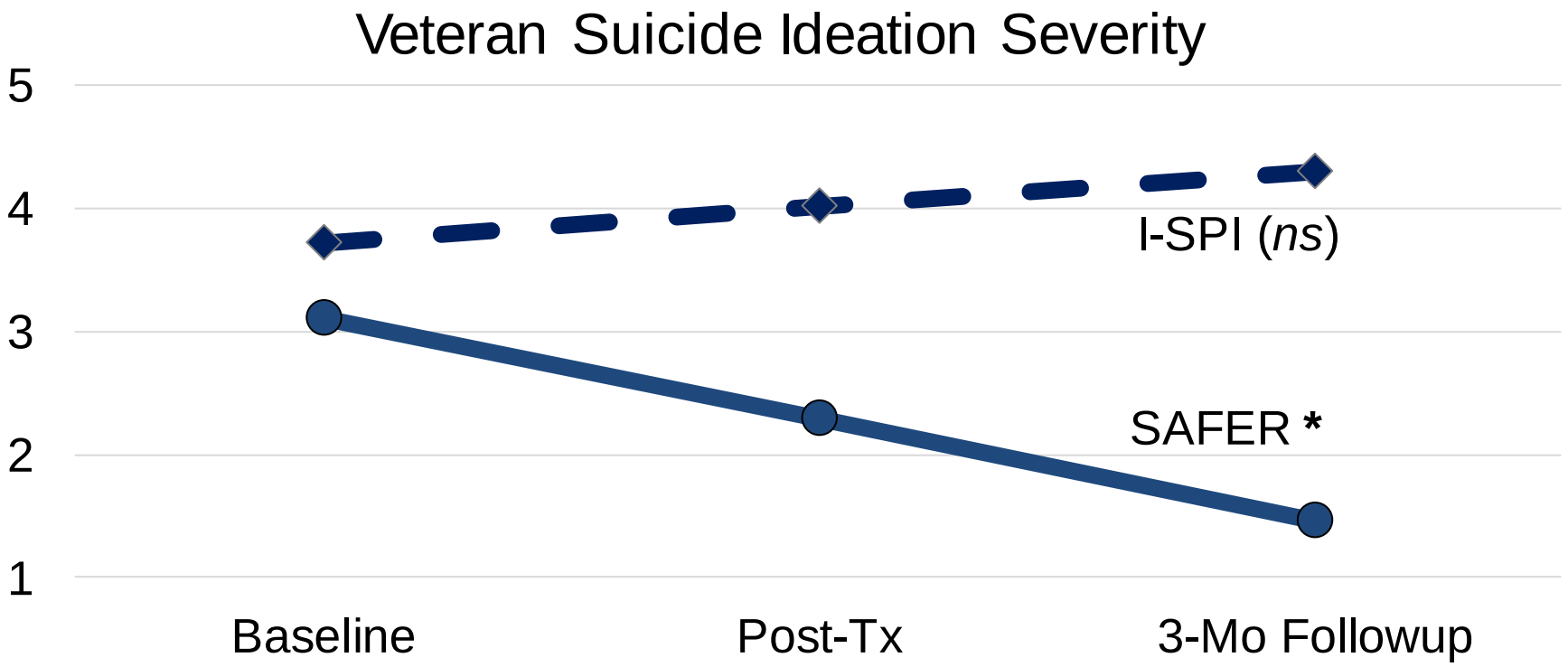
Study Design: Pilot RCT



Study Hypotheses

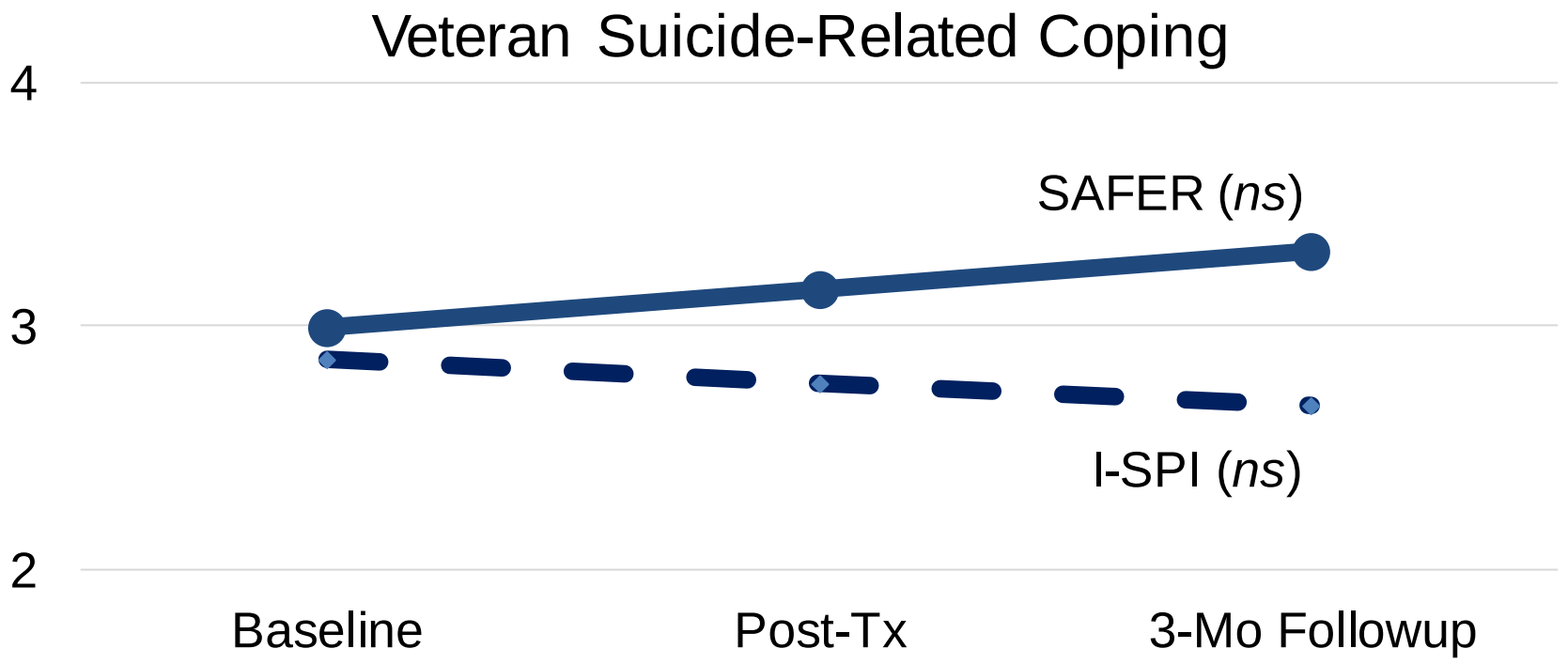
Hypothesis #	Target Veterans in SAFER will report…	Supporting Partners in SAFER will report…
1 – Ideation	⇩ **Suicide Ideation** (CSSRS; Posner et al., 2011)	---
2 – Mutual Coping	⇧ **Suicide Coping** (SRCS; Stanley et al., 2017)	⇧ **Coping Support** (Adapted SRCS)
3 – Interpersonal Cognitions	⇩ **Perceived Burden** ⇩ **Thwarted Belonging** (INQ; Van Orden et al., 2012)	⇩ **Caregiver Burden** (CBI; Novak & Guest, 1989)

Hypothesis 1: Suicide Ideation



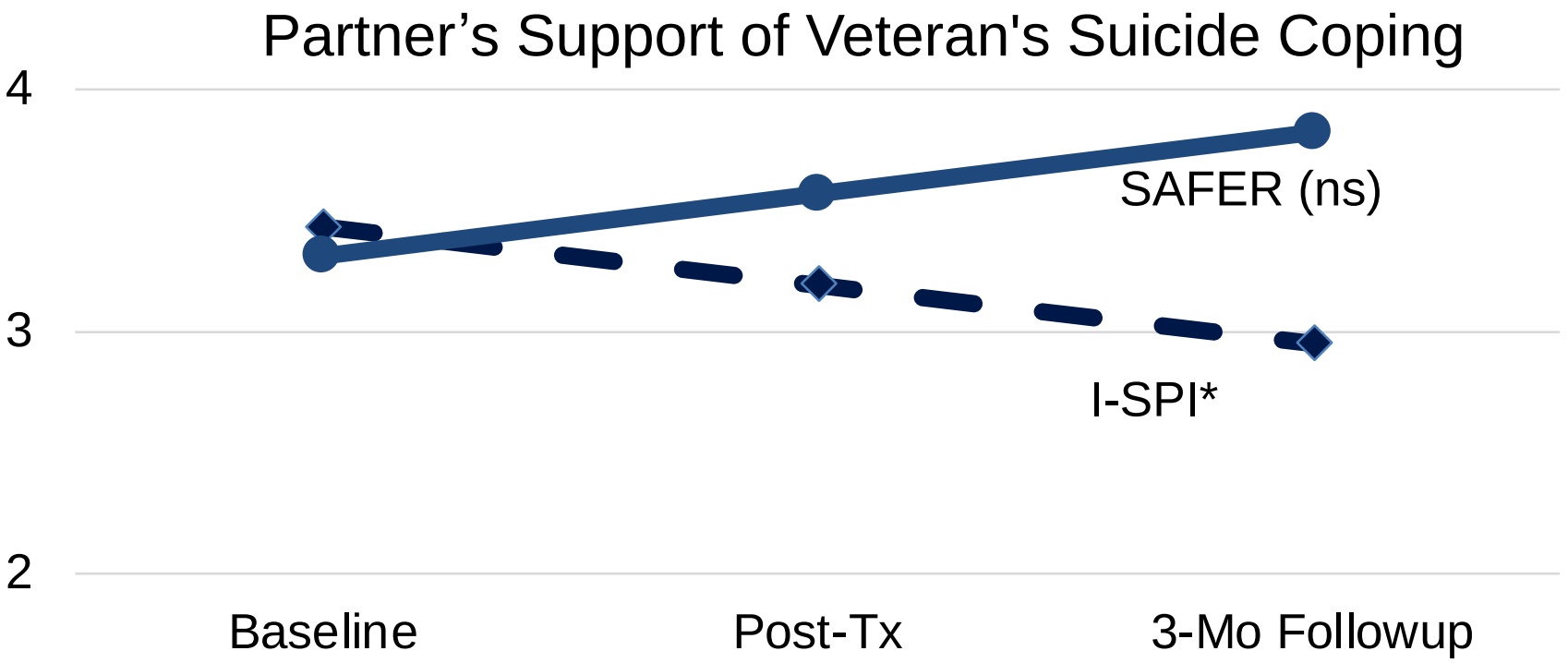
SUMMARY: *Veterans in* ***SAFER*** *experienced significant reductions in SI severity while those in* ***I-SPI*** *did not*

Hypothesis 2: Coping with Suicide



SUMMARY: *Veterans in* ***SAFER*** *felt relatively more confident that they could cope with SI than those in* ***I-SPI***

Hypothesis 2: Coping with Suicide



SUMMARY: *Supporting Partners in* **I-SPI** *lost confidence in their ability to support while those in* **SAFER** *did not.*

Hypothesis 3: Interpersonal Cognitions

- **No** significant changes in feelings of burdensomeness, belongingness for Veterans
- **No** significant improvements in caregiver burden

Conclusions

First pilot RCT of manualized family-based suicide safety planning intervention

Hypothesis #	Target Veterans	Supporting Partners
1 – ⇩ Ideation	✓	---
2 – ⇧ Mutual Coping	~	✓
3 – ⇩ Suicide-Related Interpersonal Cognitions	X	X

Changes in suicide risk are possible when supporting partners equipped with tools and support.

Limitations/ Future Directions

Limitations

- Arms not matched for treatment dosage
- Moderate suicide risk Veterans
- Recruitment and Attrition challenges (small N)
- Unable to examine moderators- gender, suicide status of Veteran, romantic partner vs spouse

Next steps

- Address how supporting partners contribute to stress
- Telehealth delivery

New Direction #3a:

- Lethal Means Safety targeted to **FAMILY**

Lethal Means Safety Resource for Family Members of Suicidal Veterans

- Project with NY Governors Challenge Team, (Lethal Means Safety sub-group) & CALM creators Cathy Barber, Elaine Frank
- Funded by NY Health Foundation (PI: Goodman) to build website/film videos
- To date, to inform the prospective training we have interviewed 25+ family members of service members and veterans in 3 groups:
  1. Family members of Veterans who died by suicide with a firearm
  2. Family members of Veterans who attempted suicide with a firearm
  3. Family members of Veterans who have firearms in their homes

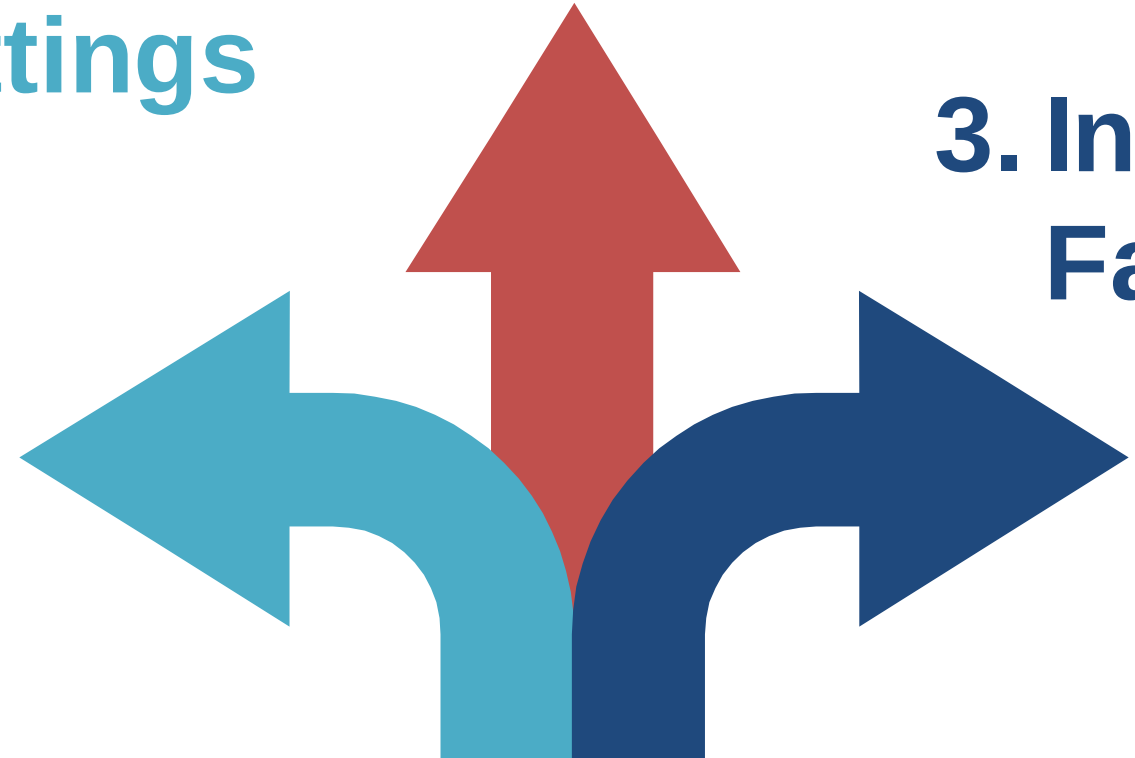
- Issues identified, scripts written, videos filmed, estimated launch date interactive website is February 2022
- The project includes building capabilities and customization for dissemination/adaptation in other states in addition to NY.

Recap: Suicide Safety Planning: New Directions

1. Group Settings

2. Telehealth Delivery

3. Involving Family



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JJPVA Suicide Research Team:

Emily Mitchell, BA

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Stephanie Gamble, PhD, Dev Crasta, PhD

PLF collaborating sites:

Maureen Monahan, PhD, Michelle Gordon, MPH, Karoline Myhre, M.Ed

Thank you!
Any questions?
Marianne.goodman@va.gov